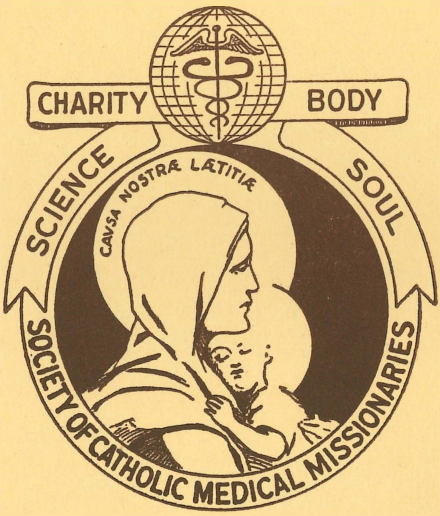
The Medical Missionary



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The MEDICAL MISSIONARY

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A JOYFUL EASTER!

The Medical Mission Sisters at home and in the mission field extend to all their readers the sincere wish of a blessed and happy EASTER filled with joyous hope in the

GLORIOUS RESURRECTION

ANNA DENGEL, M.D.

Foundress and Superior General of
The Society of Catholic Medical Missionaries

JESUS AND THE SICK

By Archbishop Alban Goodier, S.J.

Perhaps no one could fathom the depth of Christ's love of the sick as Archbishop Goodier who has made such a deep study of the gospels. As His Excellency has also spent many years in India he appreciates the importance of the Medical Apostolate. We are fortunate in having the author of the "Life of Christ" and other books give us his interpretation of Christ and the sick.—Editor.

The Old Testament rings with the praises of the mercy and goodness of God; of man's reason for boundless confidence because God never fails those who trust in Him. Indeed, if one were asked what was the special purpose of the Old Testament one would have to reply that, apart from the foreshadowing of the Messiah, it was to portray "the Lord, the Lord God, merciful and gracious, patient and of much compassion and true." And yet, if we compare the Old Testament with the New, we notice a great difference. In the Old Testament God is a merciful Lord, in the New Testament He is a forgiving Father; in the Old, He threatens, in the New, He appeals; in the Old, He forgives out of pity, in the New, He forgives out of love; in the Old, He waits for man to repent and come back to Him, in the New, He Himself goes after the lost sheep until He finds it; in the old, God "seeing that the wickedness of men was great upon the earth . . . it repented him that He had made man," in the New, He "had compassion on the multitude, because they were distressed, and lying like sheep that had no shepherd." In the Old Testament the divine compassion is born of pity and love, but the emphasis is laid upon pity; in the New Testament it is born of the same, but the emphasis is laid on love.

Perhaps a consequence of this is the great difference between the Old and the New Testament with regard to the sick and the healing of them. In the Old Testament miracles of healing are very few indeed, and those few of a special kind: the healing of the leprosy of Miriam, the sister of Moses; of the leprosy of Naaman the Syrian, perhaps the healing of Ezechias after his prayer. In the New Testament it is just the opposite: miracles of healing occupy the first place in the Gospel story, they are so common that they are taken for granted. They are not, as in the Old Testament, connected with any

special purpose, except in one single instance, but they seem to flow from our Lord as the spontaneous outpouring of Himself on whoever might need Him. If the Old Testament told of the Age of Prophecy, the New Testament described the Age of Miracles; and the link is seen in the prophecy of Isaias, with the use our Lord made of it. Isaias, in his promise of the glory of Israel to come had proclaimed:

> "Then shall the eyes of the blind be opened, and the ears of the deaf shall be unstopped. Then shall the lame man leap as a hart, and the tongue of the dumb shall be free."

And our Lord, when challenged by the disciples of John: "Art thou he that is to come? or look we for another?" answered:

> "Go and relate to John what you have heard and seen:
> The blind see,
> The lame walk,
> The lepers are made clean,
> The deaf hear,
> The dead rise again,
> To the poor the gospel is preached,
> And blessed is he whosoever shall not be scandalized in me."

Now what is specially striking in our Lord's manner is that He took this sign of healing as characteristic of Himself; so characteristic that anyone could count upon it. An officer from Capharnaum comes over to Him in Galilee to ask Him to heal his son, almost as one would go to a specialist in a distant town. A leper by the roadside says: "Lord, if thou wilt thou canst make me clean," and he is immediately healed. A sick woman presses through a crowd just to touch His garment and she is cured. Ten lepers outside a town appeal to Him and they are made sound. A begger cries: "Lord, that I may see," and at once he receives his sight. No questions are asked in any of these cases, no conditions are laid down. They are just sick people, in these and similar cases; whether good or bad we do not know. Nor is it only thus with individual cases; without any stint or limitation He heals at times every sick person put in His way. For instance, on the very first day on which He displayed His power in Capharnaum, we read:

> "And when the sun was down, all they that had any

> sick with divers diseases brought them to Him. But He, laying His hands on every one of them, healed them."

In the same way, on the day after the feeding of the 5,000, as He made His way to Capharnaum through Genesareth:

> "When the men of that place had knowledge of Him, they sent into all that country and brought to Him all that were diseased. And they besought Him that they might touch but the hem of His garment. And as many as touched Him were made whole."

Or still more strikingly in St. Mark:

> "And when they were gone out of the ship immediately they knew Him. And running through the whole country, they began to carry about in beds those that were sick, where they heard He was. And whithersoever He entered, into towns or into villages or cities, they laid the sick in the streets and besought Him that they might touch but the hem of His garment. And as many as touched Him were made whole."

Even that does not complete the story. Not only does He seem to have healed anyone who asked Him for a cure, whether for himself or for another, but often enough He bestowed His healing without being asked, out of pure compassion. Thus, to a poor cripple who did not know Him, who had begged for nearly 40 years by the pool of Bethsaida, with nobody near to witness it, He said: "Arise, take up thy bed and walk"; and to the man's astonishment he "was made whole, and he took up his bed and walked." In the same way, meeting an old woman bent double, He called her to Him and touched her, and immediately she stood up straight. It was by a spontaneous act of His own that He healed a blind man at a street corner in Jerusalem, a miracle which caused so much stir throughout the city. Nobody asked Him, nobody would have dreamt of suggesting it to Him, when, merely to stop a widow's tears, He raised her son to life. And the last of all His recorded miracles was a pure, spontaneous act of generosity, regardless of the man's deserts, when in the Garden of Gethsemane He healed the wound of one of His own captors, a "servant of the high priest" who was soon to treat Him with so much contumely.

But, for us, perhaps there is nothing more striking than the commission He gave to His twelve apostles on the first occasion that He sent them to preach. St. Matthew tells us:

> "And having called His twelve disciples together, He gave them power over unclean spirits, to cast them out, and to heal all manner of diseases, and all manner of infirmities."

This, then, was the first "power" He gave them; the others of forgiving sins, of instituting the Blessed Sacrament, of ruling the Church, were to come later. In His commission, before they started on their first missionary journey He told them:

> "Going, preach, saying: The kingdom of heaven is at hand. Heal the sick, raise the dead, cleanse the lepers, cast out devils. Freely have you received; freely give."

How they carried out this their first commission we are told by St. Mark:

> "And going forth they preached that men should do penance. And they cast out many devils, and anointed with oil many that were sick and healed them."

When at length He left them, and they went out into the world of men to fulfill His commission, we know how it was through the gift of healing that they made their appeal.

> "Silver and gold I have none; but what I have I give thee. In the name of Jesus Christ of Nazareth, arise and walk."
>
> "And Stephen, full of grace and fortitude, did great wonders and signs among the people."
>
> "For many who had unclean spirits, crying with a loud voice, went out; and many, taken with the palsy, and that were lame, were healed."
>
> "And Peter said: Eneas, the Lord Jesus Christ healeth thee. Arise and make thy bed. And immediately he arose."
>
> "Paul looking upon him, and seeing that he had faith to be healed, said with a loud voice: Stand upright on thy feet. And he leaped up and walked."

Thus throughout the Acts of the Apostles we see what an integral part the healing of the sick played in the foundation of the Church. But not only in its foundation; it is a fact, easy to establish, that care for the sick has always been an integral part of the Church's activity;

wherever, that is, she has been able to live her true life. The medical profession is a child of the Church; the nurses' profession is a child of the Church; hospitals, orphanages, asylums came first from the Church, as much as did cathedrals and universities. It was the Church that exterminated leprosy from Europe; the modern philanthropy came from her; abolish the Church today, and it is very doubtful whether the world's care for the sick would endure much longer. This at least is certain, and we see it before our eyes; that where her influence wanes there cruelty gains ground, there means are suggested for getting rid of suffering men, who are found to be a burden to mankind.

But this is to go too far away from our subject. For us what we have said brings home two facts. The first is, that whatever men may think of their suffering brethren, to care for the sick, the maimed, the incurable, the lunatic, to care for them and not to put them out of the way, is to be like our Lord Jesus Christ. It was meant as a taunt, but the cry has rung down the ages as a song of triumph, that when He himself was dying His enemies said of Him: "He saved others, Himself He cannot save." And when we come to die, if those around us can repeat the same words, that we have saved others though ourselves we cannot save, well, it will be a summary of a life well lived, and He who suffers with us will say: "Amen I say to thee, this day thou shalt be with me in paradise."

And the second thing may appeal to us yet more. After all, intense servants of God and man are inclined to leave their own reward alone; they want to do something worth doing, for God and for man, and to leave the rest to look after itself. They want, like our Lady, to glorify the Lord; they want others to glorify Him; they want "His mercy to be spread from generation unto generation to them that fear Him." They want to do that and nothing else; and when they look to Him for an inspiration as to what He would have them do, the first lesson is that they should care for the blind and the lame, the deaf and the sick, the leper and the lunatic. By this He made His own way into the hearts of men; by it He assured His disciples that they would do the same. Caring for the sick is His first weapon for the conquest of the world, and that because it is the first and most direct act of charity, the most manifest proof of our love, alike for Him and for our fellowmen. Other things are necessary, teaching, organizing, training in the various ways of life; but caring for the sick was our Lord's first way, by it He proved to those poor folk of Galilee that He cared for them every one.

THE RAWALPINDI MEDICAL MISSION TO INDIA

Twenty-fifth Anniversary

A Résumé of the Report of DOCTOR ANNA DENGEL, S.C.M.M.

In this the Jubilee Year of the foundation of the organization known as the Rawalpindi Medical Mission to India, let us briefly review the purpose and history of its foundation and the results achieved by its members.

Various factors led up to the foundation of this organization. First there was Monsignor Wagner, then Prefect Apostolic of Kashmir and Kafristan, who after 16 years in North India came to the conclusion that it was only through women, preferably Sisters, doing medical work, that India could be converted.

Then there was Doctor Agnes McLaren to whom Monsignor Wagner told his problems and dreams. The story of how she struggled to obtain women doctors for India and how she founded St. Catherine's Hospital in Rawalpindi has been ofttimes retold. It was she who persuaded me to become a missionary doctor and suggested the University College of Cork in which to study because she had found in Sir Bertram Windle, who was president at that time, an advocate of her scheme for Sisters to study medicine.

In the meantime the Rawalpindi Medical Mission to India was founded in England. This was composed of committees of ladies who worked heroically to assist in the financing of the newly opened St. Catherine's Hospital. I took charge of the hospital in 1920. The Franciscan Missionaries of Mary did the nursing. All these years the committees have carried on bravely and perseveringly. Lady Mary Howard was the president of the London Committee until her death; Lady Anne Kerr, the president of the Scotland Committee; His Eminence, Cardinal Bourne, lately deceased, the patron and one of the trustees. The reports show the names of eminent men and women interested in the cause who have given their support and encouragement.

It was while I was in charge of St. Catherine's Hospital that it became absolutely clear to me that a trained personnel was needed to cope with the exigencies of the missions. The day of untrained people, no matter how heroic they might otherwise be, was over even in the remotest parts of Asia. Missionaries, qualified as doctors and phar-

macists, or trained as nurses or midwives, were needed for hospitals, dispensaries, maternity and child-welfare work, sanatoria, leprosaria, and also to train native nurses and to open medical schools for women; in short to do every kind of medical charity in the great mission fields of the Church.

This was the motive which prompted us in 1925 to start a new religious community: The Society of Catholic Medical Missionaries. The Society was organized according to the plan Doctor McLaren had so long desired. Although it was an innovation we received much encouragement. The ice, however, was not completely broken until last year on the Feast of Our Lady of Lourdes, when the decree was issued which not only permitted but urged Sisters to study medicine and other professional medical subjects: "The Sisters should obtain certificates as doctors and nurses." This was the goal Doctor McLaren had struggled for and if she were alive today she would rejoice to see the fulfillment of her dreams.

Soon after the foundation of the Society of Catholic Medical Missionaries, Rt. Rev. Msgr. Winkley, the late Prefect Apostolic of Kashmir, invited us to undertake the work of Holy Family Hospital in the native city of Rawalpindi. It opened its doors to the first patients in February, 1928. After some time he wished to amalgamate St. Catherine's with it, so that Holy Family Hospital now represents Doctor McLaren's foundation.

The sacrifices, anxieties, joys and sorrows of the past 25 years of the committee members of the Rawalpindi Medical Mission to India and of the personnel of the hospital cannot be put into reports or statistics. A slight idea of the items that can be set down in cold figures may be gained from the following: the first report in 1911-1912 mentions six in-patients; this year's report records over 1,000 in-patients.

Our heartfelt prayers and thanks are due to all our benefactors and friends and may we express the hope that they will continue their interest and gain new friends for us in order to enable us to expand our work.

Let us thank God for all His blessings during the last 25 years and let us begin the second 25 years with as much zeal, charity and confidence as Doctor McLaren, the foundress, and the other pioneers had, that Holy Family Hospital may become an ever better and greater center of Catholic Charity. With their spirit we may hopefully look to the future.

TRIBAL TERRITORY

By Sister Mary Laetitia, S.C.M.M., R.N.

Sister Mary Laetitia is the superior of Holy Family Hospital in Rawalpindi. She is one of the original group of four who entered the Society in 1925 and has been in India since 1927. There, because of difficulties and dangers of travel, the student nurses do not go to a Center as here for examination but a group of examiners is appointed which goes periodically to the hospitals which have training schools. Sister Mary Laetitia was appointed as one of the examiners some time ago and has generously used some of her very precious time to give our readers a glimpse of "travel in India."—Editor.

I started out at Peshawar, which is right up on the frontier, about the most northern city of India, just near the Khyber Pass. In the hospital of that city there were only male nurses.

From Peshawar I went by *lorry* (bus) to Waziristan. A *tonga* (carriage) was ordered for 5.30 a. m. as the *lorry* was due to take the mail and myself from Peshawar at 6 a. m. For half an hour we waited and waited but no *tonga* turned up. Finally, about two minutes to six, along came an old bag of bones of a horse and a worse *tonga.* Needless to say I remonstrated vehemently with the driver for his late arrival and alternately urged him to hurry and at the same time protested against the use of his whip on the poor, half-starved horse.

"*Mem-sahib,*" mildly answered the old man at last, "There is plenty of time; the *lorry* will not have gone."

Of course it hadn't gone. The West will never, never learn the East. After a thousand unpunctual starts and arrivals one still confidently expects the next thing to happen on time, which it never does, except, as a rule, the trains; but they may fool one by arriving half an hour too soon, which is worse!

We reached the *lorry* starting point a few minutes after 6, but no *lorry* was in sight. It leisurely turned up around 7. So I stood and cooled my heels for nearly an hour on that bitter February morning under the shadow of snow-clad mountains and watched the people.

About 6.30 the due-on-duty-at-6 policeman arrived, squatted on his heels and discussed events of the day with fierce looking tribesmen, all armed with rifles and carrying a regular arsenal of munitions about their persons. The clothes of these tribesmen would have carpeted, draped and curtained a room vividly and picturesquely.

They would also have provided sheets, blankets, rugs, spreads and canopies for the bed. One felt sorry for those clad only in thin cotton garments and huddled into a sheet that bitter morning.

At last the punctual mail *lorry* turned up. It was simply gorgeous! All done up in red enamel, as all good mail *lorries* should be. For the roof kerosene oil cans had been commandeered, and a little later, when a reluctant sun showed its face for a few minutes, our roof shone like silver. Inside, the lining consisted of a pretty paisley material. Solomon had nothing on us!

Some miles out of Peshawar we came to a sign board which warned us that this was "Tribal Territory" and added the notice in smaller letters, "Take care. The road is narrow." We sat back happily and expectantly, in the hope of being ambushed around the next corner. Alas for our hopes! On this western side of Peshawar the tribes are all very friendly; on the eastern side such is not the case and there is always a great deal of war there. Those on the west side are so friendly, it is thought that within another ten years or so they may be disarmed, which seems a queer reward for friendliness.

Towards Bannu there is an interesting mountain road, the Kohat Pass, bordered by colorful, jagged rocks and pinnacles which would arouse the envy of a rock garden addict. There is a series of steep grades from there to Kohat, which latter place is a large military center. This whole part of the world is alive with troops.

Some miles further on one comes to Bannu which is quite the end of civilization, but a very pretty place, much warmer than Peshawar and full of English flowers in full bloom. It is guarded by big gates at every entrance, topped by rows and rows of large spikes, which give the effect of a large, circular brush upon which any number of hostile tribesmen might be impaled. These gates are closed at 6 in the evening and no European man or woman may pass outside of the city after that hour. During the day, with a male escort, women may go riding outside the gates, but if there is no such protector available they may ride only inside. In case of trouble there is a very formidable looking fort to which women and children may flee for safety.

Along the roads in the tribal territory there were scarcely any signs of activity. Very few people were in evidence; just a few men and children, the latter peeping at the daily sight of the gleaming mail *lorry* with its load of passengers and conspicuous absence of mail.

Of women there seemed to be none—apparently tribal territory functions without them. Through one or two open doors men could be seen squatting on the ground doing the cooking. There were no windows; only a few rifle holes in every wall of each house.

The tribesmen certainly look fierce enough to be the villains of any opera, with their set mouths and hard, worried looking eyes, to say nothing of the complete young armory carried all over their chests and backs. Well might one look worried living in a region where the bullets might begin to fly at any moment.

As most of the tribal lands are half or three quarters desert it is no wonder that their lives are so hard and their old men bent and worn and wrinkled as shrivelled apples. However, they are all very good tempered, and once, when along a barren stretch we saw a particularly picturesque group, I asked the easy going driver of our *lorry* to stop while I tried to get their picture. He was more than willing to oblige, and an unexpected 15 minutes' entertainment was thereby provided for the driver and passengers.

At the first request the tribesmen looked as though I were asking them to stand still and look pleasant while I pointed a machine gun at them. However, by dint of many gestures, demonstrations, and almost bodily placing them in position, I finally conveyed my meaning, and they enjoyed the *tamasha* of having their pictures taken as much as the delighted onlookers in the *lorry* behind. They twirled their *mustachios,* pointed their guns, stood at attention, looked fierce and smiling by turns, and behaved generally as all mankind when posing for a photograph.

As we continued our journey we came to a long, narrow bridge, only about two feet wider than the *lorry.* The bridge performs three functions; that of bridging the place that once was, and perhaps still is at times, a river; that of the main road; and also the railway line. It is a long bridge and seemed much longer, especially when we descried an oncoming train about to contest the right of way. However, with a gasp, we won by about two inches!

Having passed this milestone we met a camel caravan, and of all the stupid camels in the world they were the worst! Here we spent another 15 minutes while supercilious camels gazed disdainfully at us, poked their long necks into our windows and smiled derisively. Others became wildly excited and dashed to and fro, doing their utmost to impede progress.

Again driver and passengers thoroughly enjoyed themselves, jeering at the poor, harassed camel driver, and freely offering advice

as to the best method of herding an unruly flock of camels past our *lorry*. As there seemed to be no method, best or otherwise, the camel man finally gave it up as a bad job and by herculean efforts he turned his camels in the direction from which he had come and drove them up the road. For about a mile we followed the caravan at a camel's pace until we came to a place in the road where the camels could be driven off to allow us to proceed with more rapidity.

The next stop was at Dera Ismael Khan, with its railway station at Darya Khan. It was a small matter of 14 miles over a roadless stretch of territory, composed mostly of desert, including wide, dried-up river beds. Through some of these beds we were able to drive, but there were stretches through which nothing on four wheels could go. These small obstacles were overcome by a series of boats and planks, some of the boats being close, and others not so close, to each other. Between boat and boat were a few planks held together by bits of rope. Over this death-inviting arrangement we passed in an aged, slow-moving auto known as the "mail."

Darya Khan consists of nothing but a few houses, half buried in sand, and a railway station which boasts of quite a nice waiting room and some super-obliging servants. They were tumbling over each other to bring tea, hot water, cold water, clean the room, put one's baggage on the first (right or wrong) train, anything—anything for the all-powerful *bakshish* (tip), and to dispose of one as quickly as possible before the next victim should turn up, although they must be few and far between at Darya Khan.

One little sweeper boy swept the room with his *pugri* (turban), nearly asphyxiating me with the dust which just rose and bowed to him and then calmly settled again in the same spot. Then he dusted the room with the same weapon and with the same result, cleaned my muddy shoes with it, then anxiously inquired if he should put the shoes on the table, where my dusty breakfast was awaiting the cessation of his undesired activities, or on the floor. At last he departed, a big smile on his face, *bakshish* in his hand, and the over-worked *pugri* on his head.

After many amusing and terrifying incidents, the tour finally came to an end in viceregal Simla, a highly civilized termination to a trip that had covered some hundreds of miles, three weeks of time, and that seemed to have begun at one pole and ended at the other. Such was the difference in the people, conditions and climate; one day freezing in Peshawar, the next sweltering in Ambala at 104 F., and again 7,000 feet up in cold, cold Simla.

The Society at Home

WASHINGTON

Profession and Reception

This year the eleventh of February dawned a blessed and happy day for the Medical Missionaries, it being the Feast of Our Lady of Lourdes and also the day of investiture for three postulants and of profession for one novice. Through the kindness of Very Rev. Francis P. Goodall, C.S.C., superior of the Foreign Mission Seminary of Holy Cross, the ceremony again took place in the Bengalese Seminary chapel, since our own chapel is too small for a public function.

The Very Rev. Vincent S. Waters, chancellor of the Diocese of Richmond and brother of Miss Elizabeth Waters, who received the habit, presided at the ceremony. Rev. Mr. Frederick Schmidt, C.S.C., and Rev. Mr. Leo Ryan, C.S.C., were deacon and sub-deacon. Rev. Michael A. Mathis, C.S.C., was master of ceremonies.

Rev. Leonard Henry, O.F.M., who conducted the eight day retreat prior to the Feast, preached the sermon. He dwelt on the honor and privilege of being consecrated to God in a religious community which assisted broken bodies, suffering mankind and motherless children in foreign climes for God's greater glory. He recalled that it was one year ago that Rome had given official sanction to the study and exercise of professional medical work by consecrated sisterhoods, thus increasing the possibilities of health work in the mission field. By their medical and nursing skill they can endeavor to lead souls into the one fold and to recognize the one Shepherd. Happy should the Society of Medical Missionaries be for anticipating this Decree by 11 years. He further counselled the Sisters to learn of Jesus, through Mary, Queen of all religious, "our tainted nature's solitary boast." A life of comforts he did not promise them, nay not even one of consolations. Their journey of life might lead them to Egypt, Nazareth, and even perhaps to Golgotha, where they were to see "love's message written on a white Body with a ruby dye."

Sister Alma Julia, formerly Alma Le Duc, of Cleveland, Ohio, pronounced the vows of religion and took the mission oath. Those who received the holy habit were Miss Catherine Callahan, of

Annapolis, Md., in religion, Sister M. Rose; Miss Johanna Mulder, of Bathmen bij Deventer, Holland, in religion, Sister M. Joan; and Miss Elizabeth Waters, of Roanoke, Va., in religion, Sister Mary Michael.

OUR HELPERS

The Washington Auxiliary

Mrs. John Garver, of Washington, D. C., has moved to Baldwin, Long Island, N. Y. Before leaving she resigned as president of the Washington Auxiliary. In Mrs. Garver we have lost an energetic worker whose achievements will not be forgotten. January 3 election of officers for the new year took place. Miss Gertrude Roche was elected president, Mrs. Thomas Jennings, vice president; Mrs. Thomas Finnin, secretary; and Mrs. Francis Flanagan, assistant secretary. Those on the Executive Committee are Mrs. Arthur McCaleb, Mrs. Liseman and Miss N. Mitchell.

The goal of the Auxiliary has been not only to make friends for the Society of Catholic Medical Missionaries but also to raise $1,000 a year towards its needs. Miss Roche announced after the elections, "We will aim for the $1,000 goal this year." The first benefit bridge of the year was held at the home of Mrs. Conrad Vogts on February 24. It was most successful both financially and socially. Many thanks!

The Wieman Club

The Wieman Club in Brooklyn, N. Y., headed by Mrs. H. Wieman and Mrs. E. Kovacs, is doing splendid work for our Society. There are over 50 members at present and more are continually joining their ranks. They have already had one very successful card party and are planning another one for the spring.

Benefit Dance

Mrs. J. J. Shea, Mrs. E. A. Oberlin, Jr., and Mrs. John Hearty sponsored a dance at the Firestone Country Club, Akron, Ohio, January 15, for our benefit. Don Yeager's orchestra furnished the music. The purpose of the dance was to raise enough money to pay the passage of one Medical Mission Sister from Washington to India. The affair was a complete success, and as passage money is another of our worries the Motherhouse was pleased to receive the check.

Wekanduit Mission Club

During the annual retreat at Trinity College, Washington, D. C., the students prepared supplies for the maternity department and dispensary of Holy Family Hospital, Rawalpindi, India. The College Mission Club of "Wekanduits" financed and sponsored the project.

Among the articles prepared were sweaters, blankets, nightgowns, slips, shirts, hot-water bottles and covers, diapers, bandages, dressings and first-aid plasters. The articles will be sent to Holy Family Hospital with the next Sisters to go to India.

The Medical Mission Sisters wish to thank the Sisters and the students of Trinity College for their zeal and generosity.

Lots for Little Shop

For the benefit of our newer readers we must explain that the Lots for Little Shop is a thrift shop, at 902 Third Avenue, New York City, under the leadership of Miss Agnes F. Keyes, organized for the purpose of raising money for charitable and missionary organizations. The proceeds are divided among five different groups, the Society of Catholic Medical Missionaries being one of the lucky five. The semi-annual check which we receive is a welcome addition to our slender resources.

The Little Flower Mission Circle

The Little Flower Mission Circle of Harrisburg, Pa., is our oldest circle and has functioned faithfully. It has continued to realize its lofty aim—a monthly check to the Medical Mission Sisters. During the past year a number of its first and most loyal members has gone to their Heavenly Home, where they are reaping the reward of their labors for the missions. New members have joined the circle. That the L. F. M. C. may continue to be blessed by its heavenly patroness is our sincere wish and prayer.

The Hartford Exhibit

The Society of the Propagation of the Faith in the Diocese of Hartford, Conn., recently observed its annual Mission Sunday. In order to show the faithful some of the actual work being accomplished by missionaries on the field, the Reverend Joseph M. Griffin,

the Diocesan Director, exhibited a miniature of our Holy Family Hospital, Rawalpindi, in the business section of Hartford.

We are grateful to Father Griffin, one of our loyal and devoted friends, for this opportunity of bringing our work and the need of trained Medical Missionaries on the foreign mission field to the attention of the faithful of the Diocese of Hartford.

The Motherhouse Fund

Our Motherhouse Fund is growing, thanks to the generous help of the Reverend Clergy and laity. In our last issue we announced a handsome donation from one of the American Hierarchy; in this issue we are happy to say that we have received a similar sum from one of the laity, besides very many smaller sums for which we are most grateful. Alas! we are still far short of what we must have before we can buy or build.

How urgent is our need for a Motherhouse? Well, there are thirty-five who belong to this house now, and we expect more postulants in August. Our chapel seats twelve, the refectory holds fourteen (with crowding). Sleeping room? Actually we have reached the stage where the entire thirty-five of us dare not be home at the same time. Fortunately six are away—at school, begging, and showing the movie. Yesterday we received a letter from the "Beggars and Travellers." We will let you read it.

"Beggars and Travellers"

"DEAR SISTERS:

"I'm sure the Community is waiting for news of the 'beggars and travellers' in the north. Or haven't you heard the novices' way of distinguishing between those who are seeking funds and those who are showing the movie?

"Begging! An unpleasant word! But—begging for Christ! That's quite another story. When one knows that one is begging in order that more young women may join the ranks of Medical Missionaries who will devote their lives to the care of His sick and suffering, then one has the courage to beg.

"The Reverend Pastors and their Assistants whom we have met have been most kind and gracious to us. They have translated their interest in our work—and the souls we would save—into substantial

donations to aid us in procuring a new Motherhouse. We are deeply indebted to them all, as well as to the Reverend Diocesan Directors of the Society for the Propagation of the Faith, the Reverend John J. Scally of New York and the Very Reverend Monsignor John M. Hilpert of Brooklyn, who have made our appeals possible, as well as to the Daughters of Divine Charity, who in the goodness of their hearts share their cloister with us.

"While we traverse the streets of New York, our Sisters in Newark, N. J., are also hard at work. While we are asking for material assistance with which to provide suitable living quarters for our Sisters, novices and postulants, they are spreading a knowledge of the great need of medical mission work among the women of the East and the aims of the Medical Mission Sisters.

"They, too, are receiving generous cooperation from the Reverend Clergy of the Diocese of Newark and the Sisters in the hospitals and schools. The Very Rev. Msgr. William A. Griffin, Diocesan Director of the Propagation of the Faith, has graciously given them permission to show our movie, 'The Good Samaritan,' in the schools and parishes of the diocese, and the Sisters of St. Joseph of Newark are daily giving us a proof of their interest in our work by their kind hospitality to our Sisters."

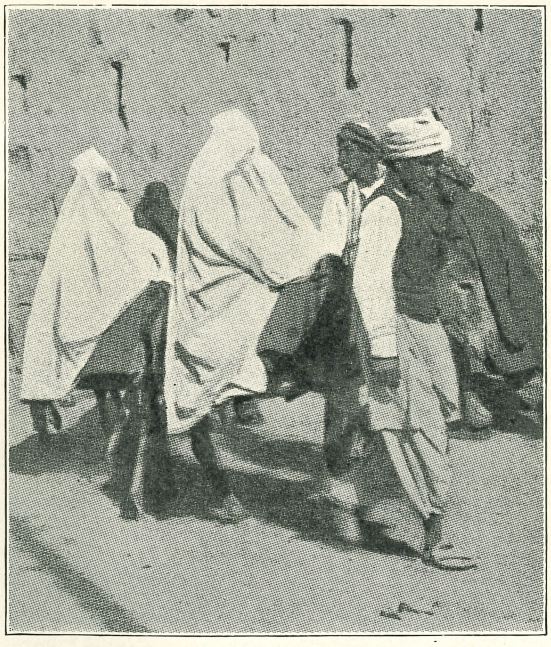
Needless to say, we at "home" are following them with our prayers with a very special plea added: "for those who do us good."

Distinguished Visitors

Among the distinguished guests at the Medical Mission House during the past three months was His Lordship, Edward Myers, Bishop-Auxiliary to the Archbishop of Westminster, England, accompanied by the Rev. Ferdinand Schoberg, S.J., of Georgetown University. Being acquainted with our work in England and interested in medical mission work, His Lordship during his short stay in Washington ventured out to the Medical Mission House on the rainy Sunday afternoon of January 31. We felt greatly honored to have Bishop Myers visit us.

The Most Reverend Francis P. Keough, Bishop of Providence, Rhode Island, a devoted friend of our Society, said Holy Mass in our little chapel several days during the week of January 31. Bishop Keough never fails to visit us when business brings him to Washington, as he is very much interested in the development of medical mission work.

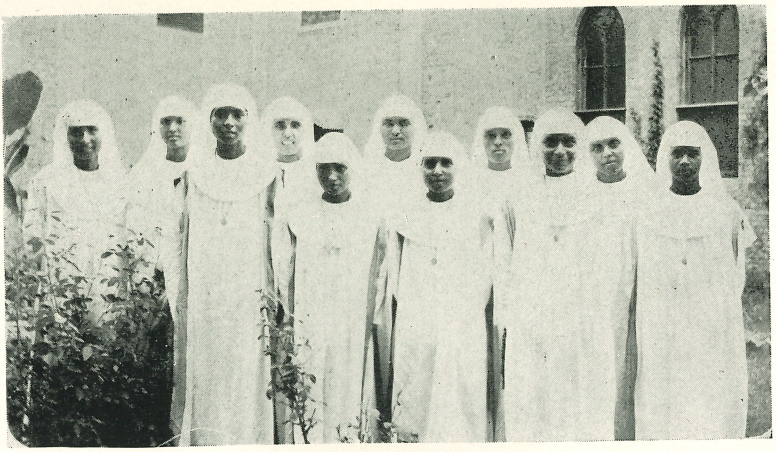
Mohammedan woman and child coming to the dispensary



Purdah patients leaving the hospital

Sister Margaret Mary, R.N., from Michigan, with two of her charges. Holy Family Hospital, Rawalpindi

An Afghan woman from "Tribal Territory"



Bengali Sisters in training at Holy Family Hospital

". . . and children, the latter peeping at the daily sight of the gleaming mail lorry" See Page 52

"The Sisters give the women the cloth and teach them how to make dresses"
See Page 65

Sister Teresa, R.N., from San Francisco—a good Samaritan in a Bengal Village

"Fierce looking tribesmen all armed with rifles."
Page 51

The Society Abroad

DACCA

The Weather

While we in Washington are having rain when we should be having snow, Sister M. Helen, S.C.M.M., R.N., from Dacca, speaks of the cold in that city where we usually hear complaints about the heat. The weather man must have mixed his maps. Listen to this: "We are having a very cold winter in Dacca. The poor suffer during the two months of cold, as they have neither bedding nor warm clothing. The Sisters at the Centers give out a large number of jute flannel dresses, but, of course, it is only a drop in the bucket. They give the women the cloth and teach them how to make the dresses, but many cannot come for sewing and so few know how to do it. It is always a great difficulty."

RAWALPINDI

In the Homes

The latest arrival at Holy Family Hospital is being initiated. In a recent letter Sister M. Vincent, S.C.M.M., tells more of her experiences.

"I had a nice visit to the Indian homes with Sister Mary Laetitia. I was delighted when she asked me to go with her, as I wanted so badly to see a real home here. We visited Father McCarty's parishioners and the *Munshi* (teacher) led the way and carried our kit.

"We went in and out of little alleys, then over a filthy lane through which only a buffalo could wade, and finally reached our first patient. Sister Mary Laetitia said she was apparently an early T.B. She was not in the best environment for recovery, but Sister gave her what treatment and advice she could.

"When we came out into the alley again we met a former patient of our Sisters; it was Joseph, a little boy who had been in our hospital for months as a result of very severe burns. When he was discharged from the hospital the burns were healed except for a little spot about

the size of a dime, but now it was a big area about four inches square. Having taken off the bandage, we found that a plaster of cow dung had been placed on the wound. No wonder so many die of tetanus when cow dung is used so generally as an antiseptic.

"Sister let me dress the wound, and advised the boy to come back to the hospital. Now he is a patient again.

"Some of the houses were fairly clean, others were filthy, and they all had the famous rows and rows of brass dishes and spoons. When clean these are very picturesque.

"I saw more sore eyes than I ever thought possible among so few people. Everyone wanted to get all the medicine they could without the trouble of coming to the hospital for it."

Outings

Sister Vincent then gives us a glimpse of the more cheerful events which have been taking place:

"One afternoon we gave a tea for Father McCarty's Christians. The Bengali Sisters (Native Sisters who are in training at the hospital) enacted a lovely little play, 'The Wise and Foolish Virgins,' and although it was in Bengali everyone enjoyed it.

"On Holy Innocents' Day the Bengali and Ajmer Sisters went to Murree and I went with them. When we reached the mountains where there was snow, all the Sisters wanted to get out of the bus to feel it. They had never seen snow before except in pictures. We trudged through the snow up to the house where our Sisters rest in the summer. After a picnic lunch we took the bus back to the hospital."

Holy Family Hospital Report

Increase of In-Patients: This year the number of our in-patients mounted to well over a thousand, in comparison with last year's eight hundred. It would have been larger but most of the year we were obliged to struggle along with only one doctor, which meant that we could not give sufficient time to the out-patients, and it is from there that we receive most of our in-patients. As we expect another doctor next month, that difficulty will be taken care of.

Building Problem: Last year our in-patients increased forty percent, this year another twenty-five percent. At this rate we shall have a hard time next year to accommodate all prospective patients, since it is difficult to turn anyone away. This brings us to the

question of building. There is a beautiful piece of land waiting to be bought for a comparatively small sum.

Native Sisterhoods: This year our Training School made a great step forward. The nurses in training are, with one or two exceptions, all native Indian Sisters.

A little over a year ago we accepted three Bengalis; a few months later we were requested to train more; now we have eleven from Bengal.* They are doing splendidly. Some of them recently took the State Examination. All did very well and one of them received honors.

About two years ago we were asked to train Native Sisters from another community in Ajmer, in the United Provinces. At the time it was impossible, but this year we were able to accept them and we now also have six Mission Sisters of Ajmer in training. They are splendid Sisters. All of them speak English perfectly, which means that we can teach them in our own language. At the same time, they know Urdu well and have a fine general education.

Recently we had a request from Patna to train some of their Native Sisters and we are hoping that we can accept six from there shortly.

Each community of Sisters has a Superior who is herself in training. All are good religious and conscientious workers. Recently the remark was made that our ward patients receive better care than the ward patients at home.

Having these Sisters from various sections means that we must have more classes in several languages, but we do not mind that since they are all hard-working, kind, conscientious nurses, with the resultant well-cared-for patients.

Obstetrical Department: Our maternity cases have increased considerably. It is certainly a great blessing for the women to get good care during confinements. We should have thousands of cases in a city this size, but many of them are still attended by native *dhais.* We get a large number of their patients after delivery, when they are suffering from septicemia!

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* The Bengali Sisters are "The Associates of Mary, Queen of the Apostles," a native sisterhood founded by Sister Rose Bernard, C.S.C., in the diocese of Dacca, Bengal. The Motherhouse is in Toomiliah.

WHAT! NO LABORATORY!!

By Sister Alma Julia, S.C.M.M., Ph.G., M.T.

The Medical Chief was making his morning rounds. The Resident was at his elbow, two internes close at his heels, the head nurse a little behind, breathlessly trying to keep up with their quicker pace and yet walk with professional dignity. Pupil nurses jumped from their chairs at the desk and frantically pulled out charts. It would never do to keep the Chief waiting 10 seconds.

The Chief did not waste much time either. He glanced at charts (the temperature sheet and the laboratory reports were about all he ever looked at) while he went from patient to patient and at the same time kept up a fired conversation with Doctor Brown, the Resident.

"What's the blood sugar this morning?" as they left the diabetic in room 20. "Report not here yet? If it's above 150 better increase the insulin, Brown, and notice if there's any diacetic. Alkalinize her if there is."

The cardio-renal case in 24 was next.

"Humph! Urea is lower. Have another one run tomorrow, Brown. If it keeps on going down increase the diet. Go slowly."

A "probie" had just finished giving "morning care" when they stepped into 26 to see her pneumonia patient. Well pleased that she had her patient "fixed" before the Chief arrived, the "probie" stepped back and smoothed her apron. She wondered if the Chief knew that she was getting her cap next week. She wondered——

"Nurse! A tongue blade," the Chief barked at her.

"She should be entirely well by now," Doctor Brown explained as they walked to the next room. "It's three weeks, however, and her temperature still goes up a little every afternoon and her cough persists for no apparent reason."

"Better have a sputum run for T.B."

And so they went from ward to ward, orders here, comments there, a consultation. The Children's Ward came last where the pediatrician was waiting to consult the Chief about a puzzling case.

"Doctor, this youngster seems to be developing meningeal symptoms now. Do you think——"

"Yes, I do. Where's the lumbar puncture tray? Got serum handy? We'll keep the needle in while we rush a specimen to the 'lab' and have them do a smear. If it looks suspicious of meningococci we'll give the serum right away. Have donors typed for transfusion too."

That was the longest speech the Chief had made that morning. He always worried more about the children.

Just then the Superintendent came into the ward. She was perturbed and actually wringing her hands. She hurried up to the Chief.

"Doctor, I'm awfully sorry, but you'll have to diagnose your cases without a laboratory for a while—perhaps for a few weeks. The pathology building was carried away by the flood last night."

"What! No laboratory!!"

THE MISSIONARY DOCTOR

Supposing the above climax was true instead of being a nightmare the Chief had after seeing movies of the flood. I can imagine him tearing his hair. I can see him rushing back to the patients he had just visited, calling for internes, nurses, charts—anything.

Yet what happens when the young doctor takes a post in some remote hospital, let's say in India? He is usually confronted with the same situation as the nightmare above, except that the news is not broken to him so dramatically; perhaps he knew it before sailing. Not only will he most likely have to diagnose his cases without laboratory tests, but to add to his difficulties there will probably not be another doctor within many miles for him to consult, he may have fewer conveniences in other lines with which to work, he will be more rushed than the Chief thought he was, and he cannot even get a good history from the patient as he could back home. He is not only the medical chief in his little hospital, but chances are he is also the surgeon, the pediatrician, the obstetrician, the whole staff. He is lucky if he doesn't have to carry out his own orders. Many of the diseases with which he is confronted are unfamiliar to him.

The mission doctor makes his morning rounds before going to the surgery for the day's operations. Before him is a very sick patient, high temperature, slightly delirious, cannot talk English or any other language with which the doctor is familiar. The patient is dehydrated and has several other serious symptoms.

"What in the world is the matter with him, anyway?" the doctor asks himself. No answer. "Is this cholera, malaria, typhoid, amoebic

dysentery?" Still no answer. "What would I do about it if I were back in New Jersey?" He knows the answer to that one. He would simply sit down at the chart desk and write out on the order sheet, "Complete blood count, widal, stool examination for amoeba, etc." Then he would give symptomatic treatment until the reports came back from the laboratory.

But the mission doctor discovers, if he didn't know it before, that he can do the laboratory examinations himself, if he has the time and the apparatus and if he hasn't forgotten what he learned in that line in medical school. Even if he is familiar with laboratory procedures and has the equipment to carry them out the overworked mission doctor usually has little enough time for his ordinary medical and surgical work without spending hours over a microscope looking for malarial parasites or amoeba histolytica.

LABORATORIES IN MISSION HOSPITALS

In *A Survey of Medical Missions in India* [1] the lack of laboratory diagnosis is commented upon as follows: "The laboratory in most of the hospitals visited is, alas, very deficient. It is usually lacking both in necessary apparatus and in personnel." Further on the report reads: "The Survey Committee found the need for developing laboratories to be so urgent that it seemed right, without waiting for the publication of this report, to carry through an arrangement to establish Training Classes for Laboratory Assistants."

How far they got in turning out laboratory assistants I do not know. Probably much progress has been made since then but when one considers the vast field to be covered and the time and equipment and personnel it takes to train laboratory technicians one cannot expect much progress in a few years.

The Protestant Church has about 300 hospitals in India,[2] the Catholic Church around 20. If the Protestant Church found conditions so lacking in their hospitals, whereas they spent very large sums to carry on their work, then what can be said of our comparatively few Catholic hospitals? Even if every hospital in India, Catholic, Protestant and Government, had good laboratory facilities, yet they

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[1] A Survey of Medical Missions in India—by the National Christian Council. 1924.

[2] Directory of Christian Missions, 1934-1935, published by the National Christian Council, Nagpur.

are so few in comparison with India's 352,000,000 population that relatively few of the people would be reached.

There are doubtless good laboratories in the larger cities, such as Bombay and Calcutta. It is like saying, "Yes, we have some laboratories in the United States. There is one in New York, another in Cleveland, one in St. Louis and one in San Francisco. How much of the population would they be able to serve? In the United States we must have at least 6,000 well-equipped laboratories in hospitals (there are over 10,000 hospitals), not counting the large amount of laboratory work done in doctors' offices and other places. Yet India has three times the population of the United States. The few laboratories in the larger cities may take care of some of its population, but India is a country of villages. Of its 352,000,000 inhabitants, 315,000,000 live in villages.[3]

At the end of the above survey [4] a subcommittee on "Equipment of a 50-bed Hospital" submitted a standard which contained the following requirements for the laboratory:

"It must provide a minimum of laboratory facilities which will permit: (a) routine urine examinations, (b) routine feces examinations, (c) blood counts, (d) examinations of blood smears, (e) examination of sputum."

To us that would be extremely inadequate, but for a mission hospital it would be very much better than nothing. At least the most essential tests could be performed. "A half-loaf is better than none."

ARE LABORATORIES SUCH A NECESSITY?

Why all this emphasis on laboratory work in mission countries? Are they really such a necessity? What kind of laboratory work must we expect to do in India?

The answers to these questions depend upon the answer to another question. That is, "Of what diseases are these people suffering?" To get that answer we might ask, "From what diseases do these people die?"

The latest Census of India, 1931, gave the following figures for the number of *deaths per year* based on the ten-year average of 1920-1929:

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[3] *Le Village Indien*—by His Excellency Msgr. Louis Gayet, M.S.F.S., Bishop of Nagpur, in Les Missions Catholiques, October 1, 1936.

[4] A Survey of Medical Missions in India.

Fevers	3,898,323
Respiratory diseases	343,254
Cholera	227,438
Dysentery and diarrhea	218,659
Plague	138,915
Smallpox	77,233

In a recent Medical Report [5] I read: "India is one of the worst foci of great infections, as plague, cholera, smallpox, yellow fever, malaria, dysentery, etc."

The terrific death rate noted in the Census above bears out that statement. If the death rates are so high what about the morbidity rates? The Medical Report from India of 1930-31 remarked that 10,000,000 malaria cases were treated in hospitals of India in one year and that probably ten times that many cases never saw a hospital. That is getting into big figures.

In *A Survey of Medical Missions in India,* the observation is made: "Most of the tropical diseases of the world are found there and practically all the maladies of the temperate climates."

The latest Census of India calls attention to the fact that India is the greatest center of smallpox in the world. That disease, however, does not require laboratory diagnosis, and the prevention of it is simple. It only illustrates how backward India is in eliminating a disease that requires nothing but vaccination to confer almost perfect and permanent immunity. Apropos of that statement we might say that prevention is the ideal, rather than treatment, of many other diseases. Theoretically it is very simple. Don't get bit by an infected mosquito and you will never get malaria. Don't get bit by an infected louse and you'll never get the plague. But killing the mosquitoes and delousing the population and other public health measures is a subject in itself.

The same Census Report also states, "Some 600,000 cases of venereal disease and 200,000 cases of tuberculosis are treated annually in hospitals but no further statistics are available." As in the case of malaria the number treated in hospitals is but a small fraction of the population affected.

Besides the diseases already mentioned we find, of course, leprosy, filarial disease, intestinal parasites, etc. As in the other cases mentioned above statistics do not give a full picture of the extent of the disease. Doctor Muir [6] and others, who have investi-

[5] India Year Book, 1935, p. 577.

[6] Census of India, 1931, p. 253.

gated the prevalence of leprosy by means of local surveys, have concluded that the census figures represent one-tenth of the actual. For instance, in a certain village, which according to the census had 10 leper cases, on opening a "clinic" whereby they persuaded the people to come for treatment, they finally found a hundred cases. The social stigma attached to leprosy made the people hide it if possible.

This is not a paper on differential diagnosis but a few facts and figures may bring home better than many words the need of accurate diagnosis, which in the majority of cases is possible only by means of laboratory tests.

Take the first item in the mortality rate mentioned above. Almost *four million deaths annually* from "Fevers." Malaria is included under "Fevers" for the simple reason that in the vast majority of cases it is not certain whether the patient died of malaria or of some other fever, as typhoid, typhus, yellow fever, or kala-azar. There is only one sure way of being positive that the patient had malaria and that is to see the parasite in the blood smear. Even then the patient may have malaria and also have another infection which may be the actual cause of death. Tuberculosis in many cases is reported under "Fevers" instead of under "Respiratory disease."

An illuminating item about kala-azar in the *Medical Report* for 1930-31 illustrates the difference correct diagnosis would make in the mortality rates: "Kala-azar . . . symptomatically it consists simply of prolonged, and on occasions, acute fever, which may in the early stage be mistaken for that of typhoid or malaria. . . . It probably has been endemic at least in Bengal and Assam for centuries, where the condition which for long had been known as *malarial cachexia* is now recognized to have been no more than kala-azar in a non-epidemic form." A little further on in the same report we read: "*Numerous* cases were and many perhaps still are called malaria which are due to kala-azar or other diseases which are not affected by quinine."

Evidently millions of patients are still being dosed with quinine on the supposition that their fever is malaria (if they are getting any medical treatment at all), while many of them might be suffering from kala-azar which has a remedy of its own. This is another digression but one I think too informative to pass over. In recent years Indian research workers have discovered a salt of antimony which when injected intravenously in kala-azar patients has reduced the former death rate of 90 per cent to the present rate of 10 per cent. Imagine epidemics of kala-azar (India still has them) where

90 per cent of the population of the village is wiped out in a few days. In the villages where kala-azar epidemics are recognized as such and antimony treatments at once instituted the death rate is only 10 per cent. The problem to reach, diagnose and treat the afflicted villages in time is still a difficult one.

The *Indian Medical Report* notes the inaccuracies of diagnosis, especially under fevers;[7] "Other unspecified 'fevers' account on the average for 3,500,000 to 4,000,000 deaths per annum, and allowing for inaccuracies of diagnosis it was until recently believed that as much as two-thirds of the deaths entered under this head should be ascribed to malaria; recent investigations made in special areas have indeed suggested that this proportion may have been considerably over-estimated, and that malaria may not account for more than one-fourth of the deaths reported as being due to 'fevers,' the remainder being mostly cases of dysentery, typhoid, pneumonia, phthisis, and so forth."

When one starts to figure out the difference between two-thirds and one-fourth of 4,000,000 people it looks as if a lot of sickness is being misdiagnosed. To avoid misconception I must mention here that even with the best laboratory facilities some cases still cannot be diagnosed or elude our best efforts to diagnose them.

What does the mission doctor do when he has a "fever" case that baffles his medical knowledge? Without laboratory facilities he may give the old-fashioned but still appropriate "quinine test." The test is something like this: You give the patient quinine; if the temperature subsides the patient had malaria; if the temperature persists the patient is suffering from some other disease. Of course it isn't scientific and it doesn't tell you what the "other disease" is but it is better than nothing. But what a waste of quinine and other drugs, what a waste of money for the mission, what inconvenience to the patient if he doesn't need the quinine.

In *A Survey of Medical Missions in India* the committee reports: "The scientific and satisfactory recognition of many important diseases is only possible with laboratory aid; e.g. the various types of malaria, the dysenteries, kala-azar, filariasis, intestinal parasites, anemias, tuberculosis, leprosy, sepsis, tumors, to mention some of the most important."

Diagnosis must come first and then the specific treatment if the terrific death rate is to be lowered, and for correct diagnoses we

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[7] India: Medical Report, 1930-31, p. 424.

need laboratories and medical technologists. There is no absolutely certain diagnosis except by laboratory tests.

The uncertainty in the diagnosis applies to other common diseases of India as well as "fevers." In the *Medical Report* [8] we read: "Owing to the difficulties of ensuring adequate investigation or diagnosis in the remoter parts of the country, deaths from various kinds of dysentery are usually recorded together with those from diarrhea."

Cholera is probably not difficult for an experienced doctor to diagnose without bacteriologic examination, but the same is not true of the other dysenteries. Bacillary and amoebic dysenteries are hard to differentiate clinically but simple to demonstrate under the microscope, and the appropriate treatment, which differs greatly in each disease, means the difference between life and death.

THE MEDICAL TECHNOLOGIST

It is evident from the above figures that there is a vast field for laboratory work in India, a field which would require a veritable army of medical technologists or laboratory assistants. Medical technologists are still somewhat scarce even in our own country. Laboratory assistants do the bulk of the examinations—some doing only one or two tests, or one branch of the work, as serology or bacteriology. A trained medical technologist should be equipped to do all types of examinations, pathologic, serologic, bacteriologic, or chemical; anything but diagnosis, which ethically still remains to the doctor.

However, the laboratory assistant has a definite place, especially in pioneer times and conditions, which conditions prevail in mission countries, and we cannot expect to demand a high standard of medical technology over night—such a standard as is required by the Registry of Medical Technologists of the American Society of Clinical Pathologists. These ideals are not yet reached even in our own country, but it is good to have a high ideal as our aim, and work for that goal.

In some places in India where they are giving courses for compounders (some kind of druggists) they are beginning to include a few essential laboratory tests in their program. One mission doctor [9] who runs a course for compounders says that he teaches his students some clinical laboratory work including the Kahn test for syphilis. As compounders usually get hospital or dispensary positions they will

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[8] India: Medical Report, 1930-31, p. 421.

[9] A Survey of Medical Missions in India.

likely have the opportunity to develop some laboratory work wherever they are located. Both professions require the same fundamental knowledge, as chemistry and physiology, although the standard for compounders in India is probably much lower than that for medical technologists in this country.

I do not want to leave the impression that nothing is being done to rectify the lack, noted above, of trained laboratory workers. On the contrary, besides the mission hospitals and missionary societies recommending improvements in that line and endeavoring to get workers in the field, the government itself is clamoring for trained malariologists, bacteriologists, public health workers and medical technologists, and it is only lack of personnel and funds that is keeping them from carrying out in full the splendid and intensive programs they are recommending. Also, with more women doctors getting into the field a larger proportion of the population is being reached, as heretofore, due to the strict practice of purdah, most medical care was available to men only.

Thus we can look forward more hopefully to the future and expect to see more progress than in the past. But India is a big, big country and it will be a long time at the best before adequate laboratory facilities will be available to meet her needs.

THE INTERNATIONAL CONGRESS OF CATHOLIC NURSES, LONDON, JULY 14 TO JULY 18, 1937

We are glad to note that the entire afternoon session of July 15th is devoted to medical work in the foreign mission field. His Grace the Archbishop of Westminster is Chairman. The speakers are R. P. Charles, S.J., representing the Belgium missions; Dr. Anna Dengel, S.C.M.M., the medical mission work in India; and Mother Kevin, the care of lepers in Africa.

We hope that many nurses from the United States and Canada will attend the Congress to enable them to learn more of what their sister nurses in other lands are doing; thus making for unified Catholic Action in the nursing profession, which our Holy Father so much desires.

Those who attend the Congress are invited to visit our Sisters at the Catholic Medical Mission House, 98 Thornbury Road, Osterley, Middlesex. It is a ten minutes' walk from Osterley Underground Station. Take a Hounslow train from Earl's Court.

FRÈRE ANDRÉ*

By Sister Alma Julia, S.C.M.M.

Frère André is dead. Newspapers and periodicals eagerly related the story of his life and works and holy death. They told of the countless thousands of people who gazed on the remains of the holy brother. They noted that the religious demonstration which took place following Frère André's death and burial, in spite of rain and slush, was exceeded only by the International Eucharistic Congress held in Montreal a few years ago.

Who is this Frère André, this "Miracle Man of Montreal," as the newspapers call him? And why are steps being taken towards his canonization?

We of the Society of Catholic Medical Missionaries feel closely related to the Congregation of Holy Cross. Our co-founder, Rev. Michael A. Mathis, is a Holy Cross priest. The Holy Cross fathers were our first instructors in the religious life, and they have assisted our Society in many ways since its foundation in 1925. Logically, therefore, we claim Frère André as one of our own brothers—well, a cousin at least.

Father Mathis was home so I decided to get some information from him about this holy Brother of his Congregation. Although Father Mathis is very busy working on his latest movie of the missions, writing articles, giving classes, and various other duties, yet I managed to obtain a hurried interview.

"Father," I said, "tell me something about Frère André. I'm writing him up in The Medical Missionary."

"Well," Father began, "he was born in——"

"Oh, no! I don't want any of that. I mean what was he *like?* You met him in Montreal and talked with him. You stayed at *Collège Notre Dame* where he lived. He is one of your own Congregation. I want to know how he *talked,* how he *acted,* what he *said.*"

Then Father Mathis gave me the description I wanted.

"He was a man of few words," Father said, "but he was a *good listener.*"

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* Frère André (Alfred Bessette) was born at Saint-Grégoire, d'Iberville, Quebec, on August 9, 1845. He entered the Congregation of Holy Cross as a lay-brother in 1870. He died on January 6, 1937, at the age of 91. A committee is already studying reported cures as a first step towards his beatification.

Ah! That explains a great deal!

It seems that immediately after Frère André finished his novitiate his superiors appointed him the porter of the boarding school for boys at *Côte-des-Neiges*. He was porter there for about forty years. Jokingly he said of himself, "My novitiate was scarcely finished when my superiors showed me the door, and I stayed there forty years—without leaving."

A porter of a boys' boarding school meets many people: parents, visitors for the priests, brothers or boys, tradesmen, beggars, the hundred and one different people who come to boarding school doors. The porter takes messages, delivers them, placates the irate, listens to complaints. He is the "buffer" between the institution and the "world."

The mothers and fathers and tradesmen and beggars began to tell their troubles to the "Brother Porter" as they waited for *Jean* or *Pierre* or the Procurator. Perhaps they lingered a little after their visits or errands were over so as to prolong their conversation with this Brother who was apparently of the common people like themselves and who listened so kindly to their tales of woe.

"He was a good listener."

Being a "good listener" seems to have led the "Brother Porter" of *Collège Notre Dame* to his special vocation as the Apostle of St. Joseph. "Good listening" implies more than just hearing what people have to say.

"Frère André was sympathetic," Father Mathis said. "He not only listened to what people had to say but he was *interested.* As you know, most of the things people have to complain of is illness. Frère André had been delicate himself as a child and all through life he was more or less sickly, which may account for his Christ-like compassion for all others who suffered."

The "Brother Porter" of *Collège Notre Dame* at *Côte-des-Neiges* knew other worries besides illness. When only nine years of age he was left an orphan, one of ten living children. From the age of twelve he made his own way in the world as best he could; shoemaker, baker, farm hand, in the cotton mills, always delicate, probably overworked and underfed, he managed to get along.

Therefore when the men and women who came to the door of the boarding school poured their troubles into Frère André's ears they found a *sympathetic listener,* one who understood their sorrows. He understood their language too; not only the *patois* of the Canadian country, but the language of human misery and pain.

"Frère André had what you might call the 'clinic' mind," Father Mathis further explained. "He got at the bottom of things. He wanted to know the details."

"Then after listening to all these people, what did he do about it?" I asked.

"He said, 'Go to St. Joseph.' "

Which brings us to the story of St. Joseph's Shrine of Mount Royal.

The Brothers of the Congregation of Holy Cross are consecrated to St. Joseph, the provider of the Holy Family. Frère André took his vocation seriously—as he took all life seriously—and to him to pray to St. Joseph was more than just an act of piety. St. Joseph meant something real to him. Surely if St. Joseph asked Our Lord for a favor He would not refuse him.

So when the sick and worried told their troubles to the "Brother Porter" he told them to pray to St. Joseph. More than that—he prayed with them and for them.

But how were they to go to St. Joseph? Most of us need more than a mental picture of the one to whom we pray. Thus our statues and paintings. Across from the *Collège Notre Dame* is a beautiful little mountain, well wooded and climbable, just the place for one to retire for prayer. The college owned the property and Frère André received the permission to erect a shrine partway up the slope. There he put a statue of St. Joseph—where he got it I don't know—and built a little roof over it; something like the wayside shrines one meets in Catholic European countries.

Now he could say to his petitioners (they were coming in crowds already), "Go to St. Joseph," and point out a definite place for them to go. Often he went with them and joined his prayers with theirs.

Answering the door-bell did not take all of Frère André's time, so naturally odd jobs fell to his lot. One of them was cutting the boys' hair, at 5 cents a cut. In the meantime the "Brother Porter" decided he wanted a chapel to house his statue of St. Joseph as the temporary shrine was entirely inadequate for the numbers of people who were flocking there, and when it rained or snowed—

Oh, all right, he could go ahead and build his chapel, but it must not cost more than $200 and he must pay for it out of his hair-cutting money. Frère André did. That was in 1904.

In 1908 a larger chapel was built with a shelter for pilgrims.

In 1910 this chapel was enlarged and a residence erected for the priests and brothers who served the pilgrims who by this time were coming in vast crowds. Even Frère André couldn't "listen" to all of them.

In 1917 a basilica was under way and the lower crypt, capable of accommodating 1,000 people, was already finished. The entire basilica is not yet complete. although it has already cost four million dollars. The clients of St. Joseph who were cured—and others—showed their gratitude.

What accounted for this tremendous influx of visitors to St. Joseph on Mount Royal? The same thing that accounts for most large pilgrimages. People wanted to be cured—and people were being cured. In late years the pilgrims that annually visited St. Joseph's Shrine on Mount Royal exceed in number those of Lourdes. If possible, they all wanted to see and talk with Frère André, the "Miracle Man." Of course, Frère André had to be relieved of his job of porter long before his death. Since 1909, in fact, he devoted all his time "listening" to the people who came to him.

It was all right for Frère André to say to the people, "Go to St. Joseph," but for the mass of humanity it was "Go to Frère André." St. Joseph's prayers are powerful in heaven, but Frère André seemed to be the one who could persuade St. Joseph to act.

"The Oratory! O what beautiful things happen at the Oratory!" were the last words of Frère André shortly before he died.

"And the weak things of the world hath God chosen that he may confound the strong." 1 Cor. 1, 27.

REVEREND BERNADINE BIDDINGER

On February 20th Reverend Bernadine Biddinger, O.F.M., of St. Boniface Monastery, Paterson, N. J., was called to his eternal reward. Long and well had he served his Master.

When our Society was founded in 1925, Father Bernadine was stationed at the Franciscan Monastery, in Brookland, D. C. When our house on Newton Street became too small for us he asked us to consider a larger house on the Franciscan property, near the Monastery. We did not consider but immediately said "Yes," and moved. A little later he was made the Superior at the Monastery.

During our three years near the Monastery (we again had to move as our numbers increased) Father Bernadine showed a fatherly interest in us, even providing us on feast days with fresh eggs from

Springtime

Medical Mission House, Osterley, England

Medical Mission House, Washington, D. C.

Rev. Michael A. Mathis, C.S.C., with Frère André, C.S.C.

the Franciscan henhouse and fruit from the Franciscan orchard. He regularly inspected our garden and flower beds, because we were considered a group of women inexperienced in such matters. We shall always cherish and hold sacred the memories of those first years.

In 1935 Father Bernadine was assigned to the Franciscan Church on Thirty-first Street, in New York, and later still was transferred to New Jersey, where he was living at the time of his last illness. He was 74 years of age. A Requiem High Mass was celebrated at the Medical Mission Sisters chapel for the repose of his soul. R. I. P.

Child Training

With the Mohammedans and Hindus the children are never too young to learn their religion. Religion is such an important thing in their lives that it is part of learning to walk and learning to talk, and it invades the most commonplace actions of every-day life. This is what Sister Frances, S.C.M.M., R.N., who directs the Maternity and Child-Welfare Centers in Dacca, has to say about the children:

"Their religious teaching begins while they are still babies and their prayers are the first words they are taught to say. When the father comes home from work he sits down and teaches them also. It isn't a one-sided job at all. No wonder these children are confirmed Hindus or Mohammedans, as the case may be, by the time they are seven or eight. One little boy of eight years was in the hospital some time ago. He had no relatives except one uncle, who was a blind beggar. This boy went out begging with his uncle and sometimes they had something to eat and sometimes they didn't. He was asked if he wouldn't like to go and stay with all the other boys. He wouldn't even consider it: he was already a soldier of Islam. He replied, 'No, you would make me a Christian and I am a follower of the true religion.' He was told he could come for a while and see, but he was firm in his refusal. The poor child was treasuring his false religion as a pearl of great price. What a pity Catholic fathers and mothers are not so zealous in teaching their little ones the truths of our faith. How often have I seen these Moslem and Hindu parents take their tiny infants, yet unable to talk, and repeat the prayers over and over to them. At two and three years of age they are being taught the ceremonials and other things. They do not regard their children as toys to say and do cute things for the entertainment of visitors but as future Hindus or Mohammedans. No wonder they have survived and are so difficult to convert."

THE "WHAT" AND THE "WHY" OF MEDICAL MISSIONS

By Reverend Michael A. Mathis, C.S.C.

This is the third article in a series on the first scientific book dealing with Catholic Medical Missions from the pen of Dr. Thomas Ohm, O.S.B., of Würzburg University, Germany. The first article was entitled "Our Savior and Medical Missions"; the second, "History of Medical Missions"; and in this I shall take up the definition and reasons for Medical Missions.

What Is the Meaning of Medical Missions?

This seems to be a rather unnecessary question, but we shall presently see that there is reason enough for it in the difference of views between Catholics and non-Catholics as to the character of this apostolate, and also in the loose usage of this terminology by some Catholics at the present time.

The terminology was invented by American and English Protestants, and originally it designated a special mission of doctors and nurses. In their own words, "A medical missionary is a fully qualified medical practitioner who combines in himself the two-fold office of Medical Man and Evangelist, a healer and a preacher. . . . A medical mission is the agency worked by one qualified as above."

The reason for employing *mission* in the terminology was the thought that a medical mission was an essential element of a Christian mission, not a mere branch of it, in contrast to the Catholic and more common German Protestant view that doctors and nurses are only a phase of the general mission work. According to the former view there would be no mission if it lacked professional medical personnel and, according to the latter, medical missions are not so essential for the Christian mission that it would cease to be a mission without professional care of the sick. Latterly, however, the Protestants are minimizing the evangelical character and emphasizing the humanitarian feature of medical missions. Hence, there is less reason than ever for them to call this apostolate a mission.

As the professional care of the sick by organized missionary groups began in the Catholic Church only recently, after a half century of Protestant efforts in this field, we naturally use the current expression popularized by non-Catholic usage. Father Linkens

(about 1911) was one of the first Catholics to discuss the problem of the terminology. He objected to "medical missions" on the ground that the professional care of the sick was not a special mission. He argued that the apostles were not sent to practise medicine, no more than Jesus was, that his miraculous cures were the result of His love and the proof of His divine mission, and that the present ministrations for the sick in the missions would be better designated by "ärztliche Fürsorge" (medical care) than by the term medical missions. Since his time Catholics, especially in Germany, have very largely used Father Linkens' terminology, and so was christened the first Catholic medical mission organization in that country (1918).

Monsignor C. Becker, S.D.S., the founder of the Catholic Medical Mission Institute of Würzburg (1922), has inserted the word "mission" into Father Linkens' expression as an adjective to show that the medical care referred to here is for the mission fields; hence, the expression "Missionsärztliche Fürsorge."

My own idea is that the German "Missionsärztliche Fürsorge" is too general a term to designate our Lord's "cure" of the sick and His command to "heal" the sick, precisely because there is a world of difference between the "care" of the sick and the "cure" or "healing" of the sick. Everyone, however, will agree with Father Linkens that medical missions do not constitute a special mission and that our Lord did not heal by medical science, nor did He explicitly command the apostles to study medicine, and neither did they cure as professional medicos. Our Lord and the apostles healed by miraculous power, and the apostles preached by the gift of tongues. Sometimes these gifts are given to missionaries even to this day, but generally speaking they are not. Hence, when they are not given there is only one way to carry out our Lord's command to "cure" the sick and to "preach" the Gospel, and that is to use the most suitable human means available. For this reason it is as necessary to study medicine in order to "heal," not just to "care" for, the sick as it is to study native languages to preach the Gospel effectively. Hence, our Lord implicitly commanded these scientific studies in so far as they are necessary to reach the objectives He so clearly pointed out.

As to our accepting the Protestant terminology which we certainly would not have chosen because through it Protestants originally wanted to express the idea of a separate and distinct mission, I think it is a tempest in a teapot for the reason that we Catholics are already

almost universally using the expression "medical missions," not in a Protestant but in a Catholic sense. It is much like the term malaria (bad air), which was first used to designate a fever because it was thought that bad air was its cause and is now still universally used to designate the same fever, despite the fact that everybody knows that malaria is transmitted by certain species of mosquitos.

More practical, however, for us Catholics is the question of our laxity in the use of the term medical missionary, designating anyone who does anything for the sick from the highly technical operations of professionals to ministering a pill by some one who knows nothing of either medicine or nursing. Certainly "medical" should not be applied to anyone who is not a professional person.

WHY CURE THE BODY?

The first reason for medical missions is the physical and spiritual well-being of everybody on the mission field, both the natives and missionaries. Since the body is an essential part of man, there is obviously a very close interrelation between it and the soul, so that the welfare of one reacts on the other.

In opposition to pagan philosophy, which so often looks upon the sick as useless, medical missions protect human personality and help the sick to become useful members of society. But the supernatural character of sanctifying grace clothes the human body with a value far above any merely human consideration. It sanctifies the body.

The second reason for medical missions is the widespread medical need in almost every mission country.

The first of these needs is a knowledge of hygiene. Many an aboriginal people like the Negritoes of the Philippines are dying out for want of elementary hygiene that affects clothing, shelter, and food. The death toll through disease is even greater. The ravages of disease among primitive people is frightful. In Uganda sleeping sickness is the principal cause for the dwindling of the population from 6,500,000 to 2,000,000 in comparatively few years. In French equatorial Africa the population decreased from 4,950,000 in 1911 to 2,822,000 in 1921. In one district the death rate for the past seven years was 30,669, while the birth rate was only 15,791.

In lands of ancient culture, such as the Near East, India, and China, hygienic conditions are, of course, better than among primitive peoples, and yet the death rate from largely preventable diseases

is very high. In India from 1915 to 1924, 2,375,857 were the victims of pest, 3,187,885 of cholera, 50,327,407 of fevers, and 2,382,298 of dysentery.

In 1935 a malaria epidemic in Ceylon carried off 54,000. Spinal meningitis in Egypt (March, 1931) laid low the population at the rate of 1,000 in two weeks with a 50 percent mortality. Every third person in Syria and Palestine suffers from Egyptian eye disease, while Egypt itself holds the record for blindness. In China the official count of the blind is 400,000.

More tragic still is the condition of women and children. In Nigeria, Africa, the infant mortality is 50 percent. "If reliable statistics could be secured," writes A. Balma, "as to the prevalence of puerperal septicemia and tetanus neonatorum in China they would undoubtedly startle the whole medical world." In India one-third of the babies die at birth. In Bengal alone, 55,000 babies die annually of tetanus. Of 1,000 children born in Bombay (1920), 556 died; while in England only 80 in a thousand succumbed. In 1932, of a thousand children born in Düsseldorf, Germany, only 70 died, while of 1,000 born the same year, 198 died in Cairo, 246 in Port Said, and 256 in eight Egyptian cities.

The distressing feature of disease in mission countries is that it is largely preventable or could be cured with proper care, or where incurable suffering could be lessened. Besides lack of sufficient medical facilities, false ideas foster suffering and death. There are those who actually welcome epidemics to weed out what they consider an over-populated land; or those who through superstition demand the death of twins, or of babies whose mothers die during child-birth, or infants born with teeth, as omens of bad luck.

The health of missionaries is a reason in itself for medical missions. For years 50 percent of the Jesuits in Bengal died within two years of their arrival on the field. Though these conditions have improved within the last decades, Colonel P. W. O'Gorman thinks that the death rate is still much higher than it should be. He estimates that Catholic missionaries still die from diseases that are from 80 to 90 percent preventable or curable.

But why should the mission take up this work? The answer is simple enough; charity, charity and more charity. Despite everything that government and native agencies can do to stem the tide of disease, there is still a great gulf between medical needs and medical facilities. In India there is only one hospital bed for every

100,000 of the population. In China only one-half of 1 percent has a chance of modern medical care, only one doctor for every 100,000 people. In Sierra Leone only one doctor for 150,000. As Dr. S. Miller says, "Everything that is being done to better medical conditions in Africa is only a drop of water on a red-hot stove."

WHY CURE THE BODY TO REACH THE SOUL?

The physical well-being of man is not the only aim of medical missions. More important still is the conversion of non-Christians to the Catholic faith. It is, of course, true that Divine Grace is the most important factor in conversion. Yet it is also true that human factors usually enter into the process by cooperating with grace in both the preparation and the work of justification. Medical missions are one of the most useful of these human factors.

In certain hostile countries, like Afghanistan, medical missions are the only possible contact with non-Christians, and in practically every mission country they are one of the most fruitful.

The noted globe-trotter, Sven Heden, observes, "Medical missions work wonders and are the key that opens the hearts of men to the Word of God." The lancet opened up Korea to Protestants. It was medicine primarily that broke down the opposition of the Maharajah to mission work in Kashmir. The same could be said of Uganda, Africa, perhaps the most fruitful Catholic Mission land in the world. Here the king went to the extent of building a residence and hospital for Protestant missions. Monsignor Demont of South Africa says that it was the hospitals that paved the way into his territory and will in turn make the district Catholic.

No authority has given the reason for medical missions more convincingly than our Holy Father, Pope Pius XI. In his famous encyclical on the missions His Holiness teaches:

"In the meanwhile, let the missioners remember that they must follow the same methods with the native as did the Divine Teacher when He was on earth. He, before He taught the multitudes, was accustomed to heal their sick, 'and all that were sick he healed; and many followed him and he healed them all; he had compassion on them and healed their sick' (Math. 8, 76; Math. 12, 15; Math. 14, 14). He ordered His Apostles to do the same, giving them the power: 'and into what city whatsoever you enter . . . heal the sick that are therein, and say to them: The Kingdom of God is come nigh unto you' (Luke 10, 8, 9) and, 'going out, they went through the towns, preach-

ing the gospel and healing everywhere. (Luke 9, 6,)' Neither let the missioners forget how kind and loving Jesus showed Himself to infants and little children; and how, when the disciples remonstrated with Him, He bade them to suffer the little children to come unto Him. (Math. 19, 13-14.) Apropos of this, let Us remind you of what We said on another occasion, namely, that all who are interested in the health of the inhabitants and minister to the sick and all who are kind to infants and little children win the good will and affection of all the natives, so readily does the human heart respond to charity and kindness."

Special opportunities present themselves for medical missions among people of certain non-Christian religions, especially among Burmese Buddhists, who are active in education but who do little by way of medical relief, and Mohammedans who can be reached sometimes only in this way. Cardinal Lavigerie instructed his missionaries to certain Mohammedan districts not to preach, but first to win the sympathy of the natives, especially by medical help.

Medical Missions, by spreading a knowledge of the natural cause of disease, often knocks the props from under religions whose superstitions attribute disease to evil spirits. This is one of the props of Animism, and to a certain extent of Hinduism also.

Even against the neo-paganism in medicine of the West, like birth control and contraceptives, which has found its way into some mission fields, particularly Japan, Catholic medical missions are a strong bulwark.

But more important still for the conversion of souls is the practical life of the medical missionary who comes into more favorable contact with non-Christians than is ordinarily possible for a priest. He preaches Catholic doctrine by his actions and explanations: the value of human life is opposed to infanticide and mutilation, the equality of all men before God; that the Christian God is one of love and not fear; and surely in the critical moments of pain and death one who lives a Divine life can say decisive words.

Finally, it is the rare privilege of the medical missionary to exemplify the characteristic mark of Christianity, namely charity, by the most literal application of our Lord's own definition of fraternal love, the parable of the Good Samaritan. This is a more powerful motive of credibility for belief in the Catholic faith than even the logic of truth, because even the dumbest man can understand it.

BAPTISM AND CATHOLIC LIFE

Not only by way of preparation for conversion do medical missions cooperate with Divine grace but also by giving many occasions for the baptism of dying infants. When one understands that annually 40,000,000 babies are born into the world and that most of these are of pagan and non-Christian parents, one realizes what a vast field this is. The statistics on these baptisms are difficult to obtain, but I am convinced from my contact with many Sisterhoods on the missions that this is one of the richest fields for the medical apostolate.

Beyond conversion and baptism, as aims of medical missions, there is also the part they play in strengthening converts to the Faith, especially against temptation to resort to pagan superstitions long associated with disease. It is also the opportunity of medical missionaries to foster practical Christian charity in converts by teaching them nursing and the care of the sick, which is looked down upon in almost every non-Christian country. But above all the preservation of the health of the Catholic community is one of the chief services of medical missions.

And finally the medical missionary has many an opportunity to foster in converts the Christian and supernatural view of family life, of motherhood, and above all of the sacredness of the human body as the temple of the Holy Ghost, as a member of the Mystical Body of Christ, and as the eternal companion of the soul in the life of heaven.

OBJECTIONS TO MEDICAL MISSIONS

Before leaving the subject of conversion as an aim of medical missions, Dr. Ohm takes up objections that have been made on this score both at home and on the mission field. Gandhi puts the chief objection this way: "I would prefer to see medical missionaries depart if they use this humanitarian aid to proselytize. According to my understanding, the people will not accept such practices. They give rise to suspicion if not to hostility."

Dr. Zacharias, long a Protestant, himself a convert to the Catholic Church in India, an able thinker and writer, answers this objection in the July, 1936, issue of THE MEDICAL MISSIONARY under the title "Fishing and Angling." He characterises Protestant mission methods, especially their medical missions, as "angling" or "baiting" unsuspecting Indians in their hospitals in contradistinction to "fishing," the Catholic method. The difference, Dr. Zacharias observes, is that Catholics do this work of charity because it is a work of

charity, content to let the work speak for itself and explaining its religious significance only where the patient shows a willingness to learn. In other words, in Catholic hospitals and dispensaries there are no "Bible women" haunting the wards and sickrooms, patients are not given medicine on condition that they attend religious instruction as is so often claimed by Hindu antagonists, and in fact there is no regular prayer or instruction for non-Catholics, although instructions would naturally be arranged for those who express a desire for it. But I am sure Dr. Zacharias does not wish to leave the impression that all Protestant medical missions deserve this stigma. In fact he says, "I am far from saying that even in Protestant medical missions propaganda is really carried on in so crude a fashion, nor would I belittle the magnificent charity and professional zeal of their staff, who, of course, only have the highest welfare of their wards in view. Still, there is enough truth in the taunt of a baited hook for us to admit that angling is not the commendable method, least of all in the sickroom."

EXPIATION FOR THE SINS OF THE WHITE MAN

Dr. Ohm makes the point that medical missions are one way of expiating in some measure at least for the extirpation, the slavery, the introduction of Western social diseases into mission countries which have almost exterminated certain tribes, wars of conquest, violence and exploitation of colonial powers and other sins of the white man against the colored.

MEDICAL MISSIONS AND PROFANE CULTURE

In the field of medical science it is remarkable what has been done by way of discoveries on the part of medical missionaries. Livingstone noticed the connection between sleeping sickness and the *tsetse* fly and called the attention of English medicine to relapsing fevers. Dr. Albert Ruskin Cook discovered the cause of sleeping sickness and stopped the extirpation of Uganda by that disease. Study of native medicine discovered quinine for malaria.

In the field of ethnology, psychology, religion and linguistics much has been contributed by missionaries. I mention only one great work, the magazine *Anthropos,* by Dr. Schmidt, S.V.D., of Vienna, and his confreres throughout the world.

HONORING GOD AND FULFILLING HIS COMMANDMENT OF LOVE

The glory of God, Dr. Ohm gives as the most potent reason for medical missions. This idea predominates in the oaths and vows

made by Catholic medical missionaries and recalls our Lord's words concerning the purpose of Lazarus's fatal sickness, "This sickness is not unto death but for the glory of God."

After God's glory, the fulfillment of His will concerning fraternal charity to the sick is the most powerful motive for medical missions. He expressed His will clearly and unmistakedly on many occasions, but perhaps never so graphically as in the parable of the Good Samaritan and in the words He will use on the last day to judge men on the basis of their practical attitude towards the sick and the afflicted.

KAPLAN GOERTZ

Just as we go to press we are happy to announce the arrival at the Medical Mission House of the Reverend Heinrich Goertz, a priest of the Diocese of Münster in Westphalia, Germany.

The Society not only welcomes Father Goertz in his unselfish dedication of himself to further our apostolate by assisting Father Mathis in his labors but also expresses its gratitude to the Most Reverend Michael J. Curley, Archbishop of Baltimore, and to His Excellency Clemens Augustinus, Count Von Galen, Bishop of Münster, who have cooperated graciously in permitting this service.

Father Goertz arrived in America on the S.S. Bremen March 8, the twelfth anniversary of his ordination to the priesthood at Münster. He had previously completed his philosophical studies at the University of Cologne, Germany, and his theological studies at the University of Innsbruck, Austria, and mission science at the University of Münster, Germany. He made these mission studies under the tutelage of Dr. Joseph Schmidlin, the father of Catholic Mission Science, and it was in those days that he and Father Mathis first met. During his priestly career in the Ruhr district, at the world renowned shrine of Kevelaer, and at Emmerich on the Rhine, Father Goertz maintained his mission interests as is seen in his writings, particularly in the book *Der Erdball in Der Stube* which is now being published.

Father Goertz leaves in his native city on the Rhine, Crefeld, his devoted parents to whom we are also grateful for their gift to the missions.

Book Reviews and Review of Reviews

ZEITSCHRIFT FÜR MISSIONSWISSENSCHAFT. Prof. Dr. J. Schmidlin. Münster, January-March, 1937.

The first article, "The Reasons for the Christianization of the Germanic Race," by Dr. P. Laurenz Kilger, O.S.B., brings up a subject which is much debated at present in certain German circles which try to prove Christianity to be foreign to the German race and forced upon them by brutal power in early centuries, thus destroying the period of high culture and enlightened faith in the pagan gods of the old Germans. The fundamental question in this problem is to give the motive why the old Germans adopted Christianity. Dr. Kilger answers it in a very critical and well-authenticated article which renders satisfactory proof that the basic reason for the conversion of the old Germans is to be found in combined factors; firstly, in the recognition of the superiority of the Christian religion over the pagan gods; secondly, the influence of teaching; and thirdly, the heroic example of those who believed in Christ, and finally the help of Divine Grace.

The second article, "The Schools in the Missions," is a contribution of Dr. Schmidlin to the topic which the Society for the Propagation of the Faith chose for the study program of 1937-1938. It consists of a historical study of the system of education and schools from the earliest times of Christianity up to the present day.

In his article, "Catholic Action in Pagan Countries," Dr. Schmidlin describes the extent of an organized Catholic Action in various mission countries of the world. The results already observed and the tasks yet to be fulfilled are briefly pointed out.

The *Missionsrundschau* contains a most valuable and extensive survey of the work done by the Germans in various mission countries of the world. The numerous facts and statistics, and especially the scholarly language used, show the thorough and scientific work done by the Münster Mission Seminary.

Some very instructive book reviews by Dr. Schmidlin conclude this number.

MARRIAGE AMONG THE YORUABA. Edward Ward. (Society of African Missions). Catholic University, 1937.

This fourth of the articles of the Catholic University of America Anthropological series deals with the marriage problem among the Yoruaba, a tribe of West Africa. Marriage among the Yoruabas, as Father Ward describes it, is principally monogamous, though based more upon pecuniary considerations than upon principle. Polygamy is the rule among the chiefs and the rich.

The author points out that if marriage interests the anthropologist, it also interests the missionary. The latter's aim is to teach the ideals of Christian family life and to instill in his charges the fundamentals of the Christian conception of marriage. In so doing he comes into close contact with the tribal marriage customs, even if he does not go out of his way to study them.

As a missionary and an anthropologist, the writer is in a position to give an accurate and interesting account of the subject he treats.

LIGUE MISSIONAIRE DES ETUDIANTS DE FRANCE. December, 1936, and January, 1937.

Under the title "News from Asia," the following interesting news items are offered in the missionary mouthpiece of the students of France.

India: The Congress of Catholic India, which was recently held, has come to the conclusion that a Catholic university has become a necessity for India, in order to "provide a more intensive Catholic formation for our intellectual elite," as His Excellency, the Apostolic Delegate, remarked.

Shanghai: The group of students, "Catholic Youth," of the University "Aurora" in Shanghai, founded in 1934 and directed by the Jesuit Fathers, is continuing and extending its activities under the able presidency of Mr. Tsiang-Hong-Li, medical student. The students visit prisons and hospitals and teach catechism to the children of the soldiers in their encampments. A medical student and a law student give free advice to the poor and aid them in their difficulties. For their classmates the group arranges conferences on problems which touch the Chinese and the modern student intimately.

The Chinese Society of St. Luc: The inaugural meeting of the newly founded Society of St. Luc was held in the auditorium of the University "Aurora" by the Catholic Chinese doctors. The purpose of the Society is to create a center for the Chinese physicians, to study medico-Catholic questions of general and local interest, and to inject into Chinese life Catholic moral principles.

L'AIDE MÉDICALE AUX MISSIONS. Brussels, October, 1936.

The Belgian organ of medical missions opens its October number with a discussion of the need and the value of fully qualified physicians in the missions. Only a fully equipped medical service can give the missionaries the physical care which they need in order to live in the tropics and to continue in good health, and to devote all their attention to the spiritual needs of the people. Moreover, medical science and art of the present day is so technical and so progressive that it may not be left in the hands of persons untrained in this special field, despite the great devotion and good will which they may bring to it. The A. M. M. has tried in its own way to meet the demands and solve the difficulties by sending out a number of doctors to the Belgian Congo and establishing small hospitals and dispensaries in that territory. The greatest scourges of the Belgian colony in tropical Africa are malaria, sleeping sickness, yaws, syphilis, leprosy, plague, and the high maternal and infant mortality. The A. M. M. from the very beginning of its existence has united its efforts with the Government projects. At present its doctors are salaried from the state and enjoy all the rights and privileges of government officials.

The next article is from the hand of Father Bosslet, O.P., the Assistant Director of the Würzburg Institute. It traces in detail the development of modern medical missions from the scattered and unorganized attempts at the beginning of this century to the well-established although still regrettably small medical mission institutes and societies of today.

IL PENSIERO MISSIONARIO. Edited by the Missionary Union of the Clergy. Rome. October and December, 1936.

The first article of the October number is a thesis written by a graduate of the Mission Science Institute of the Propaganda Fide, Father Pietro Oppio. It discusses the "Work of Evangelization in the Apostolic Prefecture of Kaffa in Ethiopia." The mixture of races found in Ethiopia, each with its own physical and psychological characteristics, makes a very complex picture, aggravated still more by the variety of languages, of which at least 40 dialects are existent. The thesis was written before the Italian invasion and does not take into account the profound changes wrought by that upheaval in the political and social organization of the country.

"Medicine in the Missions" is the title of a lecture given by Prof. Franchini of the Tropical Clinic of the University of Modena,

and it discusses in clear and concise terms the value and the need of adequate medical care for the mission countries, stressing among various arguments, the terrible ravages which tropical diseases and epidemics, unchecked and untreated, make among the helpless natives.

The December issue carries an article by Dr. Bartocetti on the much debated question of the native clergy. It is a direct answer to the discussion of Father Perbal on this same subject, published in *Pensiero's* of last year. It will be remembered that Father Perbal brought forward the question of guilt in the negligence of the early missionaries to secure the most important bulwark of the Church in foreign countries, the native clergy, at the very first moment possible. Dr. Barcetti suggests as an explanation for the tardiness in securing a native hierarchy the fact that the mission field has been divided into small territories which were entrusted each to a different order or missionary society. This system inevitably kept the native *secular* clergy out of responsible and administrative positions, no matter how generous and humble the foreign missionaries might be. But it was the only system which was practicable at the time it was instituted and at the present, under the inspired guidance of the Holy Father, these drawbacks gradually are being corrected, so that the problem of the native clergy is beginning to lose its bitterness and acuteness. Certainly nothing but praise and honor is due to those heroic missionaries of the sixteenth and seventeenth centuries who have made possible the present glorious expansion of the Kingdom of Christ on earth.

Then follows a timely study of the expanding tendencies of Mohammedanism, a topic which is a matter of grave concern to our missionaries in Africa and India, particularly in the Dutch East Indies, and which is beginning to attract attention even in America and Europe. A short biography and some interesting book reviews follow.

HIGH SPOTS ON A MISSION CRUISE, by Doctor Anna Dengel, will be continued in the next issue of THE MEDICAL MISSIONARY.

THE TWENTY-SECOND ANNUAL CONVENTION OF THE CATHOLIC HOSPITAL ASSOCIATION WILL BE HELD AT THE STEVENS HOTEL, CHICAGO, ILL., JUNE 14-18, 1937.

INTERESTING ARTICLE IN FOREIGN MAGAZINES

"Heilswille Gottes und Kirche," by Z. A. L., in "Die Katholischen Missionen," February, 1937.

This article contains a precise and logical answer to the question of why Catholics do mission work in spite of the fact that men can be saved outside the Catholic Church.

"Liturgie als Mittel zur Missionierung Japans," by Toyogi Chinda of Tokio, in "Akademische Missionsblätter," December, 1936.

"The sublime, noble and perfect representation of beauty as found in the liturgy has drawn me into the Catholic Church." The author, a Japanese convert, shows the important role the liturgy can play in the conversion of Japan.

"S. Paulus, Missionologiae Hodiernae Magister," by His Excellency Msgr. Celsus Costantini, S.C. De Propaganda Fide Secretarius, in "Collectanea Commissionis Synodalis," December, 1936.

This extraordinarily effective portrayal of St. Paul was delivered by Archbishop Costantini in the form of an address in the Gregoriana university at Rome in preparation for their Mission Sunday. The "Collectanea" article is printed in Latin; a German translation of the same material may be found in "Akademische Missionsblätter," 24 Jahrgang, 2. Heft, 1936.

"La Jeunesse aux Indes," by Joseph Segers, S.J., in "Revue Missionnaire des Jésuites Belges," January, 1937.

A thorough Catholic education of the Indian youth is pointed out as being of the greatest importance in supplying the rising generation with a means of facing a movement threatening to subvert the mental culture of India.

"Premier Congrès de Jeunesse Catholique d'Indochine," in "Les Missions Catholiques," January 1, 1937.

A former field of martyrs, the Champs de Martyrs at Nam Dinh, is the site of the first Congress of the Catholic youth of Annam, Tonkin and Cochin China, held on the Feast of Christ the King. In the same issue there is a concise article by A. Engelvin, *"Croyances et pratiques rituelles des Vézos,"* an exposition of the religious ideas and principles of the inhabitants of Madagascar.

"Die christliche Kunstausstellung in Leopoldville, 1936," by Sepp Schüller in "Die Katholischen Missionen," January, 1937.

This exhibition of Christian native art in Leopoldville (Belgian Congo) is interpreted as the beginning of African Christian art.

"Le mouvement de conversion des intouchables," by Albert Hublau, S.J., in "Revue Missionnaire des Jésuites Belges," December, 1936.

An accurate collection of information, giving the reasons for and the status of the great outcast movement in India.

"Les Iles Philipines du Grand Archipel de la Chine," by P. H. Bernard, S.J., Parts II, III and IV in the November, December and January issues, respectively, of "Collectanea Commissionis Synodalis."

The invasion of the Oriental countries by the Jesuits and Franciscans and their struggles to establish Christianity; the conquests of the English and Dutch merchants and their destruction of the foundations of religion and culture laid down by the Portuguese and Spanish missionaries; the culmination of the colonial quarrels between Portugal and Holland in the closing of Japan to all foreigners, and the beginning of a persecution of the Christians—under these heads this interesting series of historical articles is continued from the November and December issues into the first number of the new year.

"La Ligue Internationale pour la préservation de la cécité en Chine," in "Revue de l'Aucam," October, 1936.

Since 1924 there has existed in the Apostolic Vicariate of Tientstin a league for the prevention of blindness in China, founded by Dr. Lossouarn, a Catholic doctor. Its development and accomplishments are recorded.

"Lettre de S. E. Mgr. Délegué Apostolique à tous les ordinaires de Chine sur les oeuvres médical," by His Excellency Msgr. Zanin, Apostolic Delegate to China, in "Collectanea Commissions Synodalis," January, 1937.

In this letter to all the missionaries in China the writer expresses his conviction that professional medical services are most urgently required for the work in this country at the present critical times.

"Centralization, A Solution to the Problem of Christian Education for Catholic Students," by Br. Herman J. Schlund, S.M., in "Collectanea Commissionis Synodalis," November, 1936.

Another Chinese problem, the education of Catholic youth, has prompted the offer of this remedy which will be of special interest to the mission minded, since this is a difficulty as universal as it is fundamental.

"The Seventy-fifth Anniversary of the First Carmel in the Missions," in "Les Missions Catholiques," December 1, 1936.

"The 9th of October, 1861, four Carmelites arrived at Saigon from the Carmel of Lisieux and founded the first monastery in the Far East and of all the countries of the Mission." The account then tells of the many Carmelite monasteries established in mission countries since that time. It is interesting to note that the Carmel of Lisieux is the very same one in which the Little Flower, St. Therese of the Child Jesus, lived and died.

ROME HAS SPOKEN!

"It has always been the practice of this Sacred Congregation to have the methods of the apostolate conform to the varying needs of time and place. . . . This Sacred Congregation would like to see new religious institutes for women founded who will dedicate themselves principally to health work, making due provision for necessary safeguards. . . . These new duties demand a proper technical and spiritual preparation. The Sisters should obtain certificates as doctors and nurses . . ." (From the Decree of the Sacred Congregation of Propaganda Fide.)

OUR PART!

Rome's wish is Rome's command for us. We must go forward with greater energy, courage and confidence. Our most urgent need is a larger house where our young Sisters may prepare for their life's work as Medical Missionaries in India and other mission fields.

YOUR PART!

Become a partner with us in our work by your Investment in our MOTHERHOUSE FUND!

The Society of Catholic Medical Missionaries

The Society is a COMMUNITY of Sisters—doctors and nurses, who devote themselves to the care of the sick in mission countries.

Scope of the Work

The work extends to hospitals and dispensaries, medical schools and training schools for nurses, welfare centers, leper asylums, traveling dispensaries; also to visiting the sick in their homes. It affords an abundance of opportunities to combine the spiritual and corporal works of mercy.

Fields of Labor

The Society was founded for the purpose of sending qualified Sisters to India, China, Africa, and other mission countries.

Rawalpindi

At present the Society conducts a hospital for women and children in Rawalpindi, in the Mill Hill Prefecture Apostolic of Kashmir and Kafristan, India. Here, the majority of Mohammedan and Hindu women are still secluded and therefore can avail themselves only of medical aid given by women. From its beginning, this hospital has given training courses for Indian nurses in order to meet this need.

Dacca

In the Holy Cross Mission of Dacca, Bengal, members of the Society are entrusted with the nursing in the Mitford Hospital and the training school for Indian nurses. In the same city, they are in charge of two maternity and child welfare centers where they train native dhais for this work. They also make house-to-house visits for the care of the sick and the instruction of mothers.

The Sisters give classes in hygiene and home nursing in some of the schools of Dacca; also to groups of Indian women.

Requests to undertake work for the sick have been received from many mission bishops, thus showing the great need of vocations.

Requirements for Admission

The requirements for admission are:

1. A sincere desire to give oneself to God in the mission field.
2. Good health.

The age limit is 30 years.

The Society undertakes in suitable cases to provide the necessary education for all those who have not completed their studies for the medical or nursing profession. The scope of the work also calls for a large number who do not wish to do medical work directly. These do the non-medical work connected with every institution at home and in the missions.

For further information, apply to:

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MEDICAL MISSION HOUSE, *Box* 4405

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